

AMENDED IN ASSEMBLY APRIL 22, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 1962

Introduced by Assembly Member Skinner
(Coauthors: Assembly Members Bocanegra, Bonilla, Bonta, Holden,
Nestande, Pan, Waldron, and Weber)
(Coauthors: Senators Berryhill and Mitchell)

February 19, 2014

An act to amend Section 1367.003 of, and to add Section 1367.004 to, the Health and Safety Code, and to amend Section 10112.25 of, and to add Section 10112.26 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1962, as amended, Skinner. Dental plans: medical loss ratios: rebates.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a health care service plan or health insurer to comply with specified minimum medical loss ratios and requires a plan or insurer to provide an annual rebate to enrollees and insureds if the ratio of the amount of premium revenue expended by the plan or insurer on specified costs to the total amount of premium revenue is less than a certain percentage. Existing law specifies that these requirements do not apply to specialized health care service plan contracts or specialized health insurance policies.

This bill would require specialized dental health care service plan contracts and specialized dental health insurance policies to comply

with parallel requirements. The bill would authorize the departments to adopt regulations implementing these provisions and would require that those regulations parallel the regulations adopted with respect to full-service plan contracts and policies. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1367.003 of the Health and Safety Code
2 is amended to read:

3 1367.003. (a) Every health care service plan that issues, sells,
4 renews, or offers health care service plan contracts for health care
5 coverage in this state, including a grandfathered health plan, but
6 not including specialized health care service plan contracts, except
7 as provided in Section 1367.004, shall provide an annual rebate
8 to each enrollee under such coverage, on a pro rata basis, if the
9 ratio of the amount of premium revenue expended by the health
10 care service plan on the costs for reimbursement for clinical
11 services provided to enrollees under such coverage and for
12 activities that improve health care quality to the total amount of
13 premium revenue, excluding federal and state taxes and licensing
14 or regulatory fees and after accounting for payments or receipts
15 for risk adjustment, risk corridors, and reinsurance, is less than the
16 following:

17 (1) With respect to a health care service plan offering coverage
18 in the large group market, 85 percent.

19 (2) With respect to a health care service plan offering coverage
20 in the small group market or in the individual market, 80 percent.

21 (b) Every health care service plan that issues, sells, renews, or
22 offers health care service plan contracts for health care coverage
23 in this state, including a grandfathered health plan, shall comply
24 with the following minimum medical loss ratios:

1 (1) With respect to a health care service plan offering coverage
2 in the large group market, 85 percent.

3 (2) With respect to a health care service plan offering coverage
4 in the small group market or in the individual market, 80 percent.

5 (c) (1) The total amount of an annual rebate required under this
6 section shall be calculated in an amount equal to the product of
7 the following:

8 (A) The amount by which the percentage described in paragraph
9 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph
10 (1) or (2) of subdivision (a).

11 (B) The total amount of premium revenue, excluding federal
12 and state taxes and licensing or regulatory fees and after accounting
13 for payments or receipts for risk adjustment, risk corridors, and
14 reinsurance.

15 (2) A health care service plan shall provide any rebate owing
16 to an enrollee no later than August 1 of the calendar year following
17 the year for which the ratio described in subdivision (a) was
18 calculated.

19 (d) (1) The director may adopt regulations in accordance with
20 the Administrative Procedure Act (Chapter 3.5 (commencing with
21 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
22 Code) that are necessary to implement the medical loss ratio as
23 described under Section 2718 of the federal Public Health Service
24 Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations
25 issued under that section.

26 (2) The director may also adopt emergency regulations in
27 accordance with the Administrative Procedure Act (Chapter 3.5
28 (commencing with Section 11340) of Part 1 of Division 3 of Title
29 2 of the Government Code) when it is necessary to implement the
30 applicable provisions of this section and to address specific
31 conflicts between state and federal law that prevent implementation
32 of federal law and guidance pursuant to Section 2718 of the federal
33 Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial
34 adoption of the emergency regulations shall be deemed to be an
35 emergency and necessary for the immediate preservation of the
36 public peace, health, safety, or general welfare.

37 (e) The department shall consult with the Department of
38 Insurance in adopting necessary regulations, and in taking any
39 other action for the purpose of implementing this section.

(f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.

(g) Nothing in this section shall be construed to apply to provisions of this chapter pertaining to financial statements, assets, liabilities, and other accounting items to which subdivision (s) of Section 1345 applies.

(h) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 2. Section 1367.004 is added to the Health and Safety Code, to read:

1367.004. (a) A health care service plan that issues, sells, renews, or offers a specialized health care service plan contract covering dental services shall provide an annual rebate to each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health care service plan on the costs for reimbursement for clinical services provided to enrollees under that coverage and for activities that improve dental care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

1 (2) With respect to a health care service plan offering coverage
2 in the small group market or in the individual market, 80 percent.

3 (b) A health care service plan that issues, sells, renews, or offers
4 specialized health care service plan contracts covering dental
5 services in this state shall comply with the following minimum
6 medical loss ratios:

7 (1) With respect to a health care service plan offering coverage
8 in the large group market, 85 percent.

9 (2) With respect to a health care service plan offering coverage
10 in the small group market or in the individual market, 80 percent.

11 (c) (1) The total amount of an annual rebate required under this
12 section shall be calculated in an amount equal to the product of
13 the following:

14 (A) The amount by which the percentage described in paragraph
15 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph
16 (1) or (2) of subdivision (a).

17 (B) The total amount of premium revenue, excluding federal
18 and state taxes and licensing or regulatory fees and after accounting
19 for payments or receipts for risk adjustment, risk corridors, and
20 reinsurance.

21 (2) A health care service plan shall provide any rebate owing
22 to an enrollee no later than August 1 of the calendar year following
23 the year for which the ratio described in subdivision (a) was
24 calculated.

25 (d) (1) The director may adopt regulations in accordance with
26 the Administrative Procedure Act (Chapter 3.5 (commencing with
27 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
28 Code) that are necessary to implement the medical loss ratio as
29 described in this section. The regulations shall parallel the
30 regulations adopted under subdivision (d) of Section 1367.003.

31 (2) The director may also adopt emergency regulations in
32 accordance with the Administrative Procedure Act (Chapter 3.5
33 (commencing with Section 11340) of Part 1 of Division 3 of Title
34 2 of the Government Code) as necessary to implement this section.
35 The initial adoption of the emergency regulations shall be deemed
36 to be an emergency and necessary for the immediate preservation
37 of the public peace, health, safety, or general welfare. The
38 emergency regulations shall be parallel to any emergency
39 regulations adopted pursuant to subdivision (d) of Section
40 1367.003.

1 (3) The department shall consult with the Department of
2 Insurance in adopting necessary regulations, and in taking any
3 other action for the purpose of implementing this section.

4 (e) Nothing in this section shall be construed to apply to
5 provisions of this chapter pertaining to financial statements, assets,
6 liabilities, and other accounting items to which subdivision (s) of
7 Section 1345 applies.

8 (f) Nothing in this section shall be construed to apply to a health
9 care service plan contract or insurance policy issued, sold, renewed,
10 or offered for health care services or coverage provided in the
11 Medi-Cal program (Chapter 7 (commencing with Section 14000)
12 of Part 3 of Division 9 of the Welfare and Institutions Code), the
13 Healthy Families Program (Part 6.2 (commencing with Section
14 12693) of Division 2 of the Insurance Code), the Access for Infants
15 and Mothers Program (Part 6.3 (commencing with Section 12695)
16 of Division 2 of the Insurance Code), the California Major Risk
17 Medical Insurance Program (Part 6.5 (commencing with Section
18 12700) of Division 2 of the Insurance Code), or the Federal
19 Temporary High Risk Pool (Part 6.6 (commencing with Section
20 12739.5) of Division 2 of the Insurance Code).

21 SEC. 3. Section 10112.25 of the Insurance Code is amended
22 to read:

23 10112.25. (a) Every health insurer that issues, sells, renews,
24 or offers health insurance policies for health care coverage in this
25 state, including a grandfathered health plan, but not including
26 specialized health insurance policies, except as provided in Section
27 10112.26, shall provide an annual rebate to each insured under
28 such coverage, on a pro rata basis, if the ratio of the amount of
29 premium revenue expended by the health insurer on the costs for
30 reimbursement for clinical services provided to insureds under
31 such coverage and for activities that improve health care quality
32 to the total amount of premium revenue, excluding federal and
33 state taxes and licensing or regulatory fees and after accounting
34 for payments or receipts for risk adjustment, risk corridors, and
35 reinsurance, is less than the following:

36 (1) With respect to a health insurer offering coverage in the
37 large group market, 85 percent.

38 (2) With respect to a health insurer offering coverage in the
39 small group market or in the individual market, 80 percent.

1 (b) Every health insurer that issues, sells, renews, or offers health
2 insurance policies for health care coverage in this state, including
3 a grandfathered health plan, shall comply with the following
4 minimum medical loss ratios:

5 (1) With respect to a health insurer offering coverage in the
6 large group market, 85 percent.

7 (2) With respect to a health insurer offering coverage in the
8 small group market or in the individual market, 80 percent.

9 (c) (1) The total amount of an annual rebate required under this
10 section shall be calculated in an amount equal to the product of
11 the following:

12 (A) The amount by which the percentage described in paragraph
13 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph
14 (1) or (2) of subdivision (a).

15 (B) The total amount of premium revenue, excluding federal
16 and state taxes and licensing or regulatory fees and after accounting
17 for payments or receipts for risk adjustment, risk corridors, and
18 reinsurance.

19 (2) A health insurer shall provide any rebate owing to an insured
20 no later than August 1 of the calendar year following the year for
21 which the ratio described in subdivision (a) was calculated.

22 (d) (1) The commissioner may adopt regulations in accordance
23 with the Administrative Procedure Act (Chapter 3.5 (commencing
24 with Section 11340) of Part 1 of Division 3 of Title 2 of the
25 Government Code) that are necessary to implement the medical
26 loss ratio as described under Section 2718 of the federal Public
27 Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal
28 rules or regulations issued under that section.

29 (2) The commissioner may also adopt emergency regulations
30 in accordance with the Administrative Procedure Act (Chapter 3.5
31 (commencing with Section 11340) of Part 1 of Division 3 of Title
32 2 of the Government Code) when it is necessary to implement the
33 applicable provisions of this section and to address specific
34 conflicts between state and federal law that prevent implementation
35 of federal law and guidance pursuant to Section 2718 of the federal
36 Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial
37 adoption of the emergency regulations shall be deemed to be an
38 emergency and necessary for the immediate preservation of the
39 public peace, health, safety, or general welfare.

(e) The department shall consult with the Department of Managed Health Care in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

(f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.

(g) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5)), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 4. Section 10112.26 is added to the Insurance Code, to read:

10112.26. (a) A health insurer that issues, sells, renews, or offers a specialized health insurance policy covering dental services shall provide an annual rebate to each insured under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the insurer on the costs for reimbursement for clinical services provided to insureds under that coverage and for activities that improve dental care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

1 (b) A health insurer that issues, sells, renews, or offers
2 specialized health insurance policies covering dental services in
3 this state shall comply with the following minimum medical loss
4 ratios:

5 (1) With respect to a health insurer offering coverage in the
6 large group market, 85 percent.

7 (2) With respect to a health insurer offering coverage in the
8 small group market or in the individual market, 80 percent.

9 (c) (1) The total amount of an annual rebate required under this
10 section shall be calculated in an amount equal to the product of
11 the following:

12 (A) The amount by which the percentage described in paragraph
13 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph
14 (1) or (2) of subdivision (a).

15 (B) The total amount of premium revenue, excluding federal
16 and state taxes and licensing or regulatory fees and after accounting
17 for payments or receipts for risk adjustment, risk corridors, and
18 reinsurance.

19 (2) A health insurer shall provide any rebate owing to an insured
20 no later than August 1 of the calendar year following the year for
21 which the ratio described in subdivision (a) was calculated.

22 (d) (1) The commissioner may adopt regulations in accordance
23 with the Administrative Procedure Act (Chapter 3.5 (commencing
24 with Section 11340) of Part 1 of Division 3 of Title 2 of the
25 Government Code) that are necessary to implement the medical
26 loss ratio as described in this section. The regulations shall parallel
27 the regulations adopted under subdivision (d) of Section 10112.25.

28 (2) The commissioner may also adopt emergency regulations
29 in accordance with the Administrative Procedure Act (Chapter 3.5
30 (commencing with Section 11340) of Part 1 of Division 3 of Title
31 2 of the Government Code) as necessary to implement this section.
32 The initial adoption of the emergency regulations shall be deemed
33 to be an emergency and necessary for the immediate preservation
34 of the public peace, health, safety, or general welfare. The
35 emergency regulations shall be parallel to any emergency
36 regulations adopted pursuant to subdivision (d) of Section
37 10112.25.

38 (3) The department shall consult with the Department of
39 Managed Health Care in adopting necessary regulations, and in

1 taking any other action for the purpose of implementing this
2 section.

3 *(e) Nothing in this section shall be construed to apply to*
4 *disability insurance for covered benefits in the single specialized*
5 *area of dental-only health care that pays benefits on a fixed benefit,*
6 *cash payment only basis.*

7 ~~(e)~~

8 *(f) Nothing in this section shall be construed to apply to a health*
9 *care service plan contract or insurance policy issued, sold, renewed,*
10 *or offered for health care services or coverage provided in the*
11 *Medi-Cal program (Chapter 7 (commencing with Section 14000)*
12 *of Part 3 of Division 9 of the Welfare and Institutions Code), the*
13 *Healthy Families Program (Part 6.2 (commencing with Section*
14 *12693) of Division 2 of the Insurance Code), the Access for Infants*
15 *and Mothers Program (Part 6.3 (commencing with Section 12695)*
16 *of Division 2 of the Insurance Code), the California Major Risk*
17 *Medical Insurance Program (Part 6.5 (commencing with Section*
18 *12700) of Division 2 of the Insurance Code), or the Federal*
19 *Temporary High Risk Pool (Part 6.6 (commencing with Section*
20 *12739.5) of Division 2 of the Insurance Code).*

21 SEC. 5. No reimbursement is required by this act pursuant to
22 Section 6 of Article XIII B of the California Constitution because
23 the only costs that may be incurred by a local agency or school
24 district will be incurred because this act creates a new crime or
25 infraction, eliminates a crime or infraction, or changes the penalty
26 for a crime or infraction, within the meaning of Section 17556 of
27 the Government Code, or changes the definition of a crime within
28 the meaning of Section 6 of Article XIII B of the California
29 Constitution.